Virginia Healthcare-Associated Infections (HAI) Reporting

Requirements in Effect as of August 1, 2011

	The Joint Commission	VHQC / CMS	Virginia Department of Health
	Central line-associated bloodstream infection (CLABSI)	**Central line-associated bloodstream infection (CLABSI)**	**Central line-associated bloodstream infection (CLABSI)**
Required:	Required for healthcare facilities accredited by The Joint Commission	The Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program requires all Inpatient Prospective Payment System (PPS) hospitals with ICU beds to participate in this reporting requirement of the Hospital IQR Program in order to avoid a reduction in their annual payment update (APU).	Required by the *Code of Virginia* 12 VAC 5-90-370
Participants:	Healthcare facilities surveyed by The Joint Commission	All IPPS hospitals participating in the Hospital IQR Program with ICU beds.	Acute care hospitals with an adult intensive care unit (ICU)
Contacts:	http://www.jointcommission.org	Jennifer Reece: jreece@vaqio.sdps.org Sandy Gaskins: sgaskins@vaqio.sdps.org	Dana Burshell – VDH HAI Epidemiologist Dana.Burshell@vdh.virginia.gov, 804-864-7550
Timeframe:	Ongoing	January 1, 2011 – ongoing	July 1, 2008 – ongoing
Patient Population:	Intensive Care Unit (ICU) where critically ill patients with medical and/or surgical conditions are managed	Inpatients in adult, pediatric, or neonatal intensive care units	Inpatients in adult ICUs
Reporting Tool/Mechanism:	Monthly data entry into CDC's NHSN Device-Associated Module	Monthly data entry into CDC's NHSN Device-Associated Module	Monthly data entry into CDC's NHSN Device-Associated Module
Measures:	**CLABSI Numerator data** – CLABSIs (events) meeting the NHSN case definition **CLABSI Denominator data** – Patient days and central line days. NICUs will record central and umbilical lines separately, stratified by birth-weight category.	**CLABSI Numerator data** – CLABSIs (events) meeting the NHSN case definition **CLABSI Denominator data** – Patient days and central line days. NICUs will record central and umbilical lines separately, stratified by birth-weight category.	CLABSI rate per 1,000 central line days **Numerator data** –CLABSIs (events) meeting the NHSN case definition **Denominator data** – Patient days and central line days.

	Leapfrog Hospital Survey	Virginia Hospital & Healthcare Association (VHHA)	
	Central line-associated bloodstream infection (CLABSI)	**Central line-associated bloodstream infection (CLABSI)**	
Required:	Voluntary participation in the Leapfrog Hospital Survey	Voluntary participation in the Comprehensive Unit-based Safety Program (CUSP) prevention collaborative	
Participants:	Acute-care, short term general and children's hospitals. The survey was not designed for rehabilitation or psychiatric hospitals, long-term care facilities, or for hospitals that operate as units of other institutions (e.g., prison hospitals).	22 hospitals in first cohort, 11 in second cohort	
Contacts:	https://www.leapfroghospitalsurvey.org/	Barbara Brown: bbrown@vhha.com	
Timeframe:	Ongoing once facility signs contact to participate.	First cohort – March 2010 to March 2011 Second cohort – May 2012 to May 2013	
Patient Population:	Intensive/Critical care area where critically ill patients with medical and/or surgical conditions are managed. Intensive Care Unit (ICU) 80% Rule: 80% of a specific type of patient is served in the ICU type.	Inpatients in unit(s) chosen by the participating hospital. 55 hospital units participating, 40% of which are not adult intensive care units.	
Reporting Tool/Mechanism:	Monthly data entry into the Leapfrog Group online survey.	Michigan Health & Hospital Association (MHA) CareCounts database	
Measures:	Uses NHSN CLABSI definitions stratified by ICU type. **CLABSI Numerator data** – CLABSIs (events) meeting the NHSN case definition **CLABSI Denominator data** –Central line days. Rates will be stratified by ICU type. The facility's rate will be converted into a standardized infection ratio (SIR) and compared to national CLABSI rates (based	One year of baseline data are to be reported at project launch and data are to be reported monthly during the collaborative **Number of infections per month** – per NHSN case definition **Number of catheter days per month** – per NHSN definition Participation also requires completion of the Monthly Team Checkup Tool once per	

	on NHSN data). The hospital's SIR is used to determine which performance category a hospital is placed and scored accordingly.	month, survey of the safety culture at baseline and 18 months thereafter, and an exposure assessment just prior to project launch.	
	The Joint Commission	**VHQC**	**Virginia Department of Health**
	Multidrug-resistant organisms	**Methicillin-resistant Staphylococcus aureus (MRSA) infection**	**Invasive methicillin-resistant *Staphylococcus aureus***
Required:	Required for healthcare facilities accredited by The Joint Commission	CMS 9th Scope of Work (SoW)	Required: *Code of Virginia* Section 12 VAC 5-90-80, paragraph B
Participants:	Healthcare facilities surveyed by The Joint Commission	CMS-targeted critical access hospitals and IPPS hospitals that agreed to participate in the MRSA project.	Hospitals, physicians, laboratories, and other persons knowing of or suspecting a case in accordance with the provision of the statutes and regulations governing the control of communicable diseases in Virginia.
Contacts:	http://www.jointcommission.org	Jennifer Reece: jreece@vaqio.sdps.org Sandy Gaskins: sgaskins@vaqio.sdps.org	Local Health Department contact; VDH Division of Surveillance and Investigation 804-864-8141
Timeframe:	Ongoing	February 2009 – August 2011	October 2007- ongoing
Patient Population:	Established by healthcare facility. Implement a surveillance program for MDROs based on the risk assessment. Note: Surveillance may be targeted rather than hospital-wide.	Patients admitted to a designated reporting unit selected by the project hospital	Virginians
Reporting Tool/Mechanism:	Reporting period established by healthcare facility. Provide MDRO process and outcomes data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	Monthly entry into CDC's NHSN MDRO/CDAD Module (facilities were required to confer rights to VHQC as part of the agreement to participate in the project)	To: Local Health Department How: form used by the laboratory, which may include an Epi-1 form, a printout, or other form in use by the laboratory. When: Reports should be submitted within 3 days of confirmation.
Measures:	**Prevalence**: number of patients infected/colonized with an MDRO divided by the number of patients in the study population in a particular period in time.	Definition: NHSN MDRO **Report From Designated Reporting Unit ONLY** **Infection Surveillance**: Report all NHSN-defined healthcare-	VDH invasive MRSA definition: A normally sterile site is defined as blood, cerebrospinal fluid, amniotic fluid, pleural fluid, peritoneal fluid, pericardial fluid, bone and bone marrow, joint fluid, and certain internal

	Incidence: number of new MDRO cases divided by the number of people being studied in a particular period of time. **MRSA transmission rate**: number of new MDRO positive patients divided by the number of patient days times 1,000 or by the number of admissions times 100 in a particular period of time.	associated MRSA infections **LabID Events**: 1)Report first clinical MRSA culture and 2)Report unique MRSA blood cultures per patient per month **Monthly Summary Data:** 1) Number of patient days 2) Number of admissions	body sites (i.e., specimens obtained from surgery or aspirates). Urine, wounds, and sputum will not be considered sterile sites for purposes of this surveillance.
			Virginia Department of Health
			Reportable diseases and outbreaks
Required:			Required: *Code of Virginia* Section 12 VAC 5-90-80 and 12 VAC 5-90-90
Participants:			Hospitals, physicians, laboratories, and other persons knowing of or suspecting a case in accordance with the provision of the statutes and regulations governing the control of communicable diseases in Virginia.
Contacts:			Local health department contact; VDH Division of Surveillance and Investigation 804-864-8141
Timeframe:			Ongoing
Patient Population:			Virginians
Reporting Tool/Mechanism:			Who: Persons enumerated in 12 VAC 5-90-90 To: Local Health Department When: Reportable conditions should be reported within three days with the exception of specified conditions requiring communication within 24 hours (section C). Outbreaks must be reported by the most rapid means available.
Measures:			**Reportable diseases**: Suspected or confirmed cases of the specified diseases, toxic effects, and conditions. (12VAC 5-90-80)

			Outbreaks: All occurrences of clusters of any illness which may be of public health concern (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)
	The Joint Commission	**VHQC / CMS**	**Virginia Department of Health**
	Surgical site infections (SSI)	**Surgical site infections (SSI)**	**Surgical site infections (SSI)**
Required:	Required for healthcare facilities accredited by The Joint Commission	CMS will require all Inpatient Prospective Payment System (IPPS) hospitals participating in the Hospital IQR Program to report SSI data in order to avoid a reduction in their annual payment update.	Voluntary
Participants:	Healthcare facilities surveyed by The Joint Commission	All IPPS hospitals participating in the Hospital IQR Program.	Hospitals that volunteered to participate in the pilot (18)
Contacts:	http://www.jointcommission.org	Jennifer Reece: jreece@vaqio.sdps.org Sandy Gaskins: sgaskins@vaqio.sdps.org	Dana Burshell – VDH HAI Epidemiologist Dana.Burshell@vdh.virginia.gov, 804-864-7550
Timeframe:	Ongoing	***To begin January 1, 2012***	June 2010 – June 2011
Patient Population:	Established by healthcare facility. Implement a surveillance program for SSIs organisms based on the risk assessment. Note: Surveillance may be targeted rather than hospital-wide.	Persons undergoing colon surgery or abdominal hysterectomy, as defined by NHSN	Persons undergoing coronary artery bypass graft, hip replacement, or knee replacement surgery, as defined by NHSN
Reporting Tool/Mechanism:	Reporting period established by healthcare facility. Provide SSI process and outcomes data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	Monthly data entry into the CDC's NHSN Procedure-Associated Module	Monthly data entry/upload to CDC's NHSN Procedure-Associated Module Monthly submission of Excel spreadsheet with time and effort sent directly to VDH
Measures:	Definition: NHSN SSI **Numerator data** – Surgical site infections	Definition: NHSN SSI **Numerator data** – Surgical site infections	Definition: NHSN SSI **Numerator data** – Surgical site infections

	(events) meeting the NHSN case definition **Denominator data** – number of surgical procedures	(events) meeting the NHSN case definition **Denominator data** – as defined by NHSN. Information required on each surgical procedure conducted.	(events) meeting the NHSN case definition following CABG, HPRO, or KPRO surgery **Denominator data** – as defined by NHSN. Information required on each surgical procedure conducted. Monthly time and effort associated with surveillance, data entry, and reporting (in hrs)
		VHQC	**Virginia Department of Health**
		Surgical Care Improvement Project (SCIP)	**SCIP measures**
Required:		The Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program requires all inpatient Prospective Payment System (PPS) hospitals to report SCIP clinical measures data in order to avoid a reduction in their annual payment update (APU).	
Participants:		IPPS hospitals as a requirement of the IQR program. Several Critical Access Hospitals report data voluntarily as a part of the CMS Hospital Quality Alliance Initiative	SSI surveillance pilot hospitals that volunteered to participate in the SCIP component of the pilot (17)
Contacts:		David Hall: dhall@vaqio.sdps.org Sandy Gaskins: sgaskins@vaqio.sdps.org	Dana Burshell – VDH HAI Epidemiologist Dana.Burshell@vdh.virginia.gov, 804-864-7550
Timeframe:		January 2005 - ongoing	Jan 2010 – December 2010
Patient Population:		Patients, 18 years or older, admitted to the to the hospital for inpatient acute care for an *ICD-9-CM Principal Procedure Code* for SCIP as defined in the Specifications Manual for National Hospital Inpatient Quality Measures. There are eight distinct strata or sub-populations within the SCIP Topic	Persons undergoing coronary artery bypass graft, hip replacement, or knee replacement surgery, as defined by CMS

		Population, each identified by a specific group of procedure codes.	
Reporting Tool/Mechanism:		Quarterly data upload (by submission deadline) to the CMS Clinical Data Warehouse. Typically hospitals utilize a vendor and their software – hospital data is entered into the software program by hospital, vendor edits and uploads to the warehouse.	Quarterly submission of Excel spreadsheet directly to VDH
Measures:		**SCIP-Inf-1** Antibiotic w/in 1 Hour **SCIP-Inf-2** Recommended Antibiotic **SCIP-Inf-3** Antibiotic Discontinued **SCIP-Inf-4** Glucose Controlled **SCIP-Inf-6** Appropriate Hair Removal **SCIP-Card-2** Beta-Blocker During Peri-op **SCIP-VTE-1** VTE Ordered **SCIP-VTE-2** VTE Timely	**SCIP-Inf-1** Antibiotic w/in 1 Hour **SCIP-Inf-2** Recommended Antibiotic **SCIP-Inf-3** Antibiotic Discontinued Report compliance specific to procedure under surveillance in SSI pilot (# patients meeting measure, # total eligible patients) Time and effort associated with reporting these three measures to VDH (in minutes)
	The Joint Commission	**Leapfrog Hospital Survey**	**VHQC / CMS**
	Catheter-Associated Urinary Tract Infections	**Catheter-Associated Urinary Tract Infections**	**Catheter-Associated Urinary Tract Infections**
Required:	Required for healthcare facilities accredited by The Joint Commission	Voluntary participation in the Leapfrog Hospital Survey	The Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program requires all Inpatient Prospective Payment System (PPS) hospitals with ICU beds to participate in this reporting requirement of the Hospital IQR Program in order to avoid a reduction in their annual payment update (APU).
Participants:	Healthcare facilities surveyed by The Joint Commission	Acute-care, short term general and children's hospitals. The survey was not designed for rehabilitation or psychiatric hospitals, long-term care facilities, or for hospitals that operate as units of other institutions (e.g., prison hospitals).	All IPPS hospitals participating in the Hospital IQR Program with ICU beds.
Contacts:	http://www.jointcommission.org	https://www.leapfroghospitalsurvey.org/	Jennifer Reece: jreece@vaqio.sdps.org Sandy Gaskins: sgaskins@vaqio.sdps.org

Timeframe:	January 1, 2012 - onward	Ongoing once facility signs contact to participate.	***To begin January 1, 2012***
Patient Population:	Established by healthcare facility. Implement a surveillance program for CAUTIs based on the risk assessment. Note: Surveillance may be targeted rather than hospital-wide. This national patient safety goal *excludes* the pediatric population.	Hospital-wide	Acute care hospitals Patients in adult and pediatric intensive care units
Reporting Tool/Mechanism:	Reporting period established by healthcare facility. Provide CAUTI process and outcomes data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.	Monthly data entry into the Leapfrog Group online survey.	Monthly data entry into CDC's NHSN Device-Associated Module
Measures:	**Numerator data**: CAUTIs (events) meeting the NHSN case definition. **Denominator data**: Urinary catheter days	As of 2011, only process measures* reported (see below), not CAUTI rates. Full credit requires compliance with each process measure.	Percentage of intensive care unit patients with catheter-associated urinary tract infections **Numerator data:** CAUTIs (events) meeting the NHSN case definition **Denominator data:** Urinary catheter days
	The Joint Commission	**Leapfrog Hospital Survey**	
	Hand Hygiene	**Hand Hygiene**	
Required:	Required for healthcare facilities accredited by The Joint Commission	Voluntary participation in the Leapfrog Hospital Survey	
Participants:	Healthcare facilities surveyed by The Joint Commission.	Acute-care, short term general and children's hospitals. The survey was not designed for rehabilitation or psychiatric hospitals, long-term care facilities, or for hospitals that operate as units of other institutions (e.g., prison hospitals).	
Contacts:	http://www.jointcommission.org	https://www.leapfroghospitalsurvey.org/	
Timeframe:	Ongoing	Ongoing once facility signs contact to participate.	

Patient Population:	Hospital-wide	Hospital-wide	
Reporting Tool/Mechanism:	Established by healthcare facility; typically monthly.	Monthly data entry into the Leapfrog Group online survey.	
Measures:	**Numerator data**: the number of compliant hand hygiene observations for a given period and/or location. **Denominator data**: total number of hand hygiene observations for a given period and/or location.	As of 2011, only process measures* reported (see below), not hand hygiene compliance rates. Full credit requires compliance with each process measure.	

	Leapfrog Hospital Survey		
	Ventilator-associated pneumonia		
Required:	Voluntary participation in the Leapfrog Hospital Survey		
Participants:	Acute-care, short term general and children's hospitals. The survey was not designed for rehabilitation or psychiatric hospitals, long-term care facilities, or for hospitals that operate as units of other institutions (e.g., prison hospitals).		
Contacts:	https://www.leapfroghospitalsurvey.org/		
Timeframe:	Ongoing once facility signs contact to participate.		
Patient Population:	Areas where ventilator patients are managed.		
Reporting Tool/Mechanism:	Monthly data entry into the Leapfrog Group online survey.		
Measures:	As of 2011, only process measures* reported (see below), not VAP rates. Full credit requires compliance with each process measure.		

More information on **The Joint Commission**:

CAUTI: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: *Surveillance may be targeted to areas with high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital's risk assessment as required in IC.01.03.01, EP 2.*

- During 2012, plan for the full implementation of this NPSG by January 1, 2012. Note: Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating timelines, identifying resources, and pilot testing.
- Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
    - Limiting use and duration to situations necessary for patient care
    - Using aseptic techniques for site preparation, equipment and supplies
- Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
    - Securing catheters for unobstructed urine flow and drainage
    - Maintaining the sterility of the urine collection system
    - Replacing the urine collection system when required
    - Collecting urine samples
- Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
    - Selecting measures using evidence-based guidelines or best practices
    - Monitoring compliance with evidence-based guidelines or best practices
    - Evaluating the effectiveness of prevention efforts

MDRO: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: *This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram negative bacteria.*

- Conduct periodic risk assessments (in time frame defined by the hospital) for multidrug- resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5).
- Based on the results of the risk assessment, educate staff and licensed independent practitioners about health-care associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.
    - *Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.*
- Educate patients and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection strategies.
- Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. Note: Surveillance may be targeted rather than hospital-wide.
- Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
    - Multidrug-resistant organism infection rates using evidence-based metrics
    - Compliance with evidence-based guidelines or best practices
    - Evaluation of the education program provided to staff and licensed independent practitioners
    - ***Note:*** *Surveillance* may be targeted rather than hospital-wide.
- Provide multidrug-resistant organism process and outcomes data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
- Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
- When indicated by the risk assessment, implement a laboratory-based alert system that identified new patients with multidrug-resistant organisms.
    - ***Note:*** *The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.*
- When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

- ***Note 1.*** *This alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.*
- ***Note 2.*** *Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.*

Hand hygiene: Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

- Implement a program that follows categories 1A, 1B, and 1C of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guideless. (See also IC.01.04.01, EP 5).
- Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP).
- Improve compliance with hand hygiene guidelines based on established guidelines.

CLABSI: Implement best practices or evidence-based guidelines to prevent central line-associated infections.

Note: *This requirement covers short and long term central venous catheters and peripherally inserted central catheter (PICC) lines.*

- Educate staff and licensed independent practitioners who are involved in managing central lines about central line-associated bloodstream infections, and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement of these procedures is added to an individual's job responsibilities.
- Prior to insertion of a central venous catheter, the hospital educated patients, and as needed their families about central line-associated bloodstream infection prevention.
- Implement policies and practices aimed at reducing the risk of central line-associated bloodstream infections that meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
- Conduct periodic risk assessments for central line-associated bloodstream infections, monitor compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital-wide, not targeted.
- Provide CLABSI rate data and prevention outcomes measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.
- Use a catheter checklist and a standardized protocol for central venous catheter insertion.
- Perform hand hygiene prior to catheter insertion or manipulation.
- For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.
- Use a standardized supply cart or kit that is all inclusive for the insertion of central venous catheters.
- Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion.
- Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over two months of age, unless contraindicated.
- Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.
- Evaluate all central venous catheters routinely and remove nonessential catheters.

Surgical site infections: Implement best practices for preventing surgical site infections.

- Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections, and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities.
- Educate patients and their families as needed, who are undergoing a surgical procedure about surgical site infection preventions.
- Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines
- As part of the effort to reduce surgical site infections:
    - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital
    - Select surgical site infection measures using best practices or evidence-based guidelines, monitor compliance with best practices or evidence-based guidelines, evaluate the effectiveness of prevention efforts.
    - ***Note:*** *Surveillance may be targeted to certain procedures based on the hospital's risk assessment.*
- Measure surgical site infection rates for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices. The hospital's measurement strategies follow evidence based guidelines.
    - ***Note:*** *Surveillance may be targeted to certain procedures based on the hospital's risk assessment.*

- Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.
- Administer antimicrobial agents for prophylaxis used for a particular procedure or disease according to evidence-based best practices.
    - Administer intravenous antimicrobial prophylaxis within one hour before incision (two hours are allowed for the administration of vancomycin and fluoroquinolones).
    - Discontinue the prophylactic antimicrobial agent within 24 hours after surgery (within 48 hours is allowable for cardiothoracic procedures).
- When hair removal is necessary, the hospital uses clippers or depilatories.
    - ***Note:*** *Shaving is an inappropriate hair removal method.*

More information on **Leapfrog**:

Safe practice process measures – facility has done the following processes or has had the following in place within the last 12 months

Hand hygiene

- Undertaken a hospital-wide education effort addressing the frequency and severity of hospital-acquired infections resulting from inadequate hand hygiene within pt population and potential impact of performance improvement practices related to the absence of or inadequate hand hygiene
- Submitted a report to the Board (governance) with recommendations for measurable improvement targets
- Accountability for this patient safety area through performance reviews or compensation: Senior and Clinical leadership , Patient Safety or designee
- Conducted staff education/knowledge transfer and skill development programs, with attendance documented
- Documented expenditures on staff education related to this Safe Practice in the previous year
- Implemented explicit organization policies and procedures across the entire organization to prevent hospital-acquired infections due to inadequate hand hygiene including CDC guidelines with category IA, IB, or IC evidence
- Implemented a formal performance improvement program addressing hospital-acquired infections focused on hand hygiene compliance, with regular performance measurement and tracking improvement ***or***
- Monitored a previously implemented hospital wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice.

CLABSI

- Performed a hospital-wide evaluation of the frequency of incidents of central venous catheter-related bloodstream infections
- Completed a literature review and identified specific best practices for process redesign
- Submitted a report to the Board (governance) with recommendations for measurable improvement targets
- Accountability for this patient safety area through performance reviews or compensation: Senior and Clinical Leadership, Patient Safety or designee
- Conducted staff education/knowledge transfer and skill development programs on central venous catheter-related bloodstream infection prevention, with attendance documented
- Allocated compensated staff time to work on this Safe Practice
- Documented or can document expenses incurred during the past year tied to this Safe Practice
- Implemented explicit organization policies and procedures that include appropriate adult or pediatric specific bundle elements to prevent the occurrence of central venous catheter-related blood stream infections
- Implemented a formal performance improvement program addressing central venous catheter-associated blood stream infections (with regular performance measurement and tracking improvement) ***or***
- Monitored a previously implemented hospital wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice

VAP

- Conducted an evaluation of the frequency and severity of ventilator associated complications in the patient population and communicated findings to senior and clinical leadership.
- Submitted a report to the Board (governance) with recommendations for measurable improvement targets
- Accountability for this patient safety area through performance reviews or compensation: Senior and Clinical Leadership, Patient Safety or designee
- Conducted staff education/knowledge transfer and skill development programs on best practices and strategies to reduce complications with attendance documented
- Documented or can document expenses incurred during the past year tied to this Safe Practice
- Allocated compensated staff time to work on this Safe Practice
- Documented evidence that all ventilated patients are included in an appropriate adult or pediatric specific bundle or prevention plan that is clearly documented in the medical record
- Implemented explicit organizational policies for the disinfection, sterilization, and maintenance of respiratory equipment that are aligned with evidenced based guidelines
- Documented evidence that all ventilated patients and/or their families have been educated on prevention measures involved in the care of the ventilated patient

- Implemented a formal performance improvement program with regular performance measurement and tracking improvement addressing ventilator associated complication prevention and compliance with prevention strategies ***or***
- Monitored a previously implemented hospital wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice

CAUTI

- Perform a hospital-wide evaluation of the frequency of incidents of catheter associated urinary tract infections and communicated findings to senior and clinical leadership.
- Submitted a report to the Board (governance) with recommendations for measurable improvement targets
- Accountability for this patient safety area through performance reviews or compensation: Senior and Clinical Leadership, Patient Safety or designee
- Conducted staff education/knowledge transfer and skill development programs, including education for all new employees upon hire and for individuals whose responsibilities now include involvement in these procedures
- Documented or can document expenses incurred during the past year tied to this Safe Practice
- Implemented evidence based practices across the organization aimed at preventing the occurrence of urinary catheter-related infections
- Implemented explicit organization policies to educated patients (or family, as appropriate) who require a urinary catheter about catheter associated urinary tract infection prevention
- Implemented a formal performance improvement program addressing catheter associated urinary tract infections (with regular performance measurement and tracking improvement) ***or***
- Monitored a previously implemented hospital wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice